MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8213

CERTIFICATE OF DEATH

08184

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 11yrs.5mo.30days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburgh

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS: 97 Steuben Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES Middle W. Last BANNON

4. DATE OF DEATH: Month August Day 8 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-9-1887

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Bannon

14. MOTHER'S MAIDEN NAME: Mary Tracey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary arteriosclerosis, severe	unknown
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial fibrosis	unknown
DUE TO (c)	Infarcts of the lungs, bilateral, multiple	10-15 days

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized, severe (unknown)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 9, 1945, to August 8, 1956 that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 9:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. DATE SIGNED: 8-10-56

PHYSICIAN'S NAME (Type): W. OPPLER Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-10-56

22c. NAME OF CEMETERY OR CREMATORY: Unknown

22d. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: [illegible] Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 8-10-56

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8214

CERTIFICATE OF DEATH

08185

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. D. #4, Elkton, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
d. STREET ADDRESS: R. D. #4, Elkton, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lissie Middle Oaks Last Barnett
4. DATE OF DEATH: Month August Day 4, Year 1956
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 22, 1888
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clement Oaks
14. MOTHER'S MAIDEN NAME: Sarah Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 242125141
17. INFORMANT Address: Mr. Paul Barnett, RD #4, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 7 days
331X
DUE TO (b): Essential hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 28, 1956, to Aug. 4, 1956, that I last saw the deceased alive on July 28, 1956, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Kenneth W. Eskew, M.D. ADDRESS (Street, city or town, state): Brookside, Newark, Del. DATE SIGNED:

PHYSICIAN'S NAME (Type): Kenneth W. Eskew

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-7-56
22c. NAME OF CEMETERY OR CREMATORY: Faggs Manor Cemetery
22d. LOCATION (City, town, or county) (State): Russellville, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: W. H. Pippin ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 8/6/56
24b. REGISTRAR'S SIGNATURE: H R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8215

CERTIFICATE OF DEATH

08186 58

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. D. , North East
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Elkton R. D. 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE — Middle P. — Last BIRD

4. DATE OF DEATH: Month August — Day 28 — Year 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 11, 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert Phillips

14. MOTHER'S MAIDEN NAME: Mary Margaret Poteet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. William H. Ross, R.D.3 Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	1 hr.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Chronic Nephritis	3 yrs.
DUE TO (c)	Hypertension	3 yrs.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to Aug 28, 1956, that I last saw the deceased alive on Aug 27, 1956, and that death occurred at 3:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Jacob J. Greenwald — ADDRESS (Street, city or town, state): Elkton md — DATE SIGNED

PHYSICIAN'S NAME (Type): Jacob J. GREENWALD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 1, 1956

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth. Cem.

22d. LOCATION (City, town, or county) (State): Cecil County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
Ralph E. Hicks, Bow & Stockton Sts.
ADDRESS: Elkton

24a. REC'D BY REGISTRAR DATE: Aug 31-56

24b. REGISTRAR'S SIGNATURE: Emm Worthington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08187

8216

CERTIFICATE OF DEATH

Reg. Dist. No. 9C

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit
c. LENGTH OF STAY IN 1b 8 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit
d. STREET ADDRESS 200 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Lewellah Middle: Susan Last: Brenneman

4. DATE OF DEATH Month: Aug. Day: 15 Year: 1956

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1866

9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months 11 Days 15 IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Crossroads, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Kessey

14. MOTHER'S MAIDEN NAME: Fannie Meades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lillian Young Address: Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
422.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Senility / obstruction — 4 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 56, to 8-15, 19 56, that I last saw the deceased alive on 8-16, 19 56, and that death occurred at 2:20 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE G.H. Richards M.D. ADDRESS (Street, city or town, state) Box 40 Kos. T, Md. DATE SIGNED 8-15-56

PHYSICIAN'S NAME (Type) G.H. Richards, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 18 1956

22c. NAME OF CEMETERY OR CREMATORY: Winters Town Evangical

22d. LOCATION (City, town, or county) (State): Winters Town Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert McCue ADDRESS: Red Lion, Pa.
Harry D. Burg Funeral Home
Lee A. Patterson's Son Perryville, Md.

24a. REC'D BY REGISTRAR DATE 8-15-56

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08188

Item 4 FilmG202 9-6-56 et

8217

CERTIFICATE OF DEATH

Reg. Dist. No. 90

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City

LENGTH OF STAY (in this place): 2 wks.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Morgan Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

STREET ADDRESS (If rural give location): RD #2

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Knight (Last) Bryant

4. DATE OF DEATH (Month) (Day) (Year): Aug. 28, 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	WHITE	Divorced	Jan. 4, 1875	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housekeeping	England	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas James Bryant	Knight

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	—	Charles H. Bryant, Elkton, RD #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 IMMEDIATE CAUSE (A): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B): Hypertensive C.V. Disease — 3 years

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15, 1956, to Aug 29, 1956, that I last saw the deceased alive on Aug 28, 1956, and that death occurred at 6.40 A.M., from the causes and on the date stated above.

SIGNATURE: Henry Davis M.D. ADDRESS (Street, city, town, state): Chesapeake City, Md. DATE SIGNED: 8/29/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial		Woodlawn	Baltimore Md.

24. RECD BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
AUG 31 1956	Mrs. Ralph H. Reese	Wm. J. Pickner & Sons - Balto Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8218

Reg. Dist. No. 08189 96

1. PLACE OF DEATH
a. COUNTY: CECIL
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA
b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 17yrs9mos17days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: 1354 S. Carolina Avenue, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEE Middle Last CAMPBELL
4. DATE OF DEATH: Month August Day 26 Year 1956

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 15, 1899
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (State or foreign country): Brandy, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM CAMPBELL
14. MOTHER'S MAIDEN NAME: LUCINDA KEITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records, VAH., Address: Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Meningitis, acute — INTERVAL BETWEEN ONSET AND DEATH: Unknown

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Bronchopneumonia — Aprox. 4days

DUE TO (c): Chronic Brain Syndrome associated with Central nervous system syphilis. (Meningoencephalitic) — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I VA attended the deceased from November 9, 1938, to August 26, 1956, [illegible] and that death occurred at 12:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. C. Grasberger, M.D.
ADDRESS (Street, city or town, state): VA HOSPITAL, Perry Point, Md.
DATE SIGNED: 8-26-56

PHYSICIAN'S NAME (Type): J. C. GRASBERGER, M. D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 8-26-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Ft. Myer, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: HOFFMAN FUNERAL HOME,
ADDRESS: 611 "K" Street, N.W., Washington, D.C.
24a. REC'D BY REGISTRAR DATE: 8-26-56
24b. REGISTRAR'S SIGNATURE: Irene E. Daughtry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68190

CERTIFICATE OF DEATH

8219

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 29yrs 9mos 28days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ESSEX, BALTIMORE 03-54-2
d. STREET ADDRESS: 301 East Montrose Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD; Middle: N.; Last: CZARNECKY

4. DATE OF DEATH: Month: August; Day: 3; Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 20,1897

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 5/3/22 to 5/14/23

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, lower lobes, — INTERVAL BETWEEN ONSET AND DEATH: 4 to 5 days
DUE TO: unresolved
(b): Arteriosclerosis of coronary artery — Unk.
DUE TO
(c):

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis general, moderate.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 6th, 1926, to August 3, 1956 that I last saw the deceased alive on [illegible], and that death occurred at 5:20 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Grasberger M.D. — ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Maryland. — DATE SIGNED

PHYSICIAN'S NAME (Type): JOSEPH GRASBERGER, Actg. Dir. Prof. Services, VA Hospital, Perry Point, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-4-56

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Essex Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: JOHN G. CONNELLY FUNERAL HOMES, 418 Eastern Ave. Essex 21, Md.

24a. REC'D BY REGISTRAR — DATE: 8-4-56

24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08191

CERTIFICATE OF DEATH

8208

Reg. Dist. No. 92

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Elkton

LENGTH OF STAY (in this place): 3 days.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Cecil

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Elkton

STREET ADDRESS (If rural give location): RFD #1.

3. NAME OF DECEASED (Type or Print): (First) RAY (Middle) ALLEN (Last) FISHER

4. DATE OF DEATH: (Month) 8 (Day) 21 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Baby	8.18.56	— yrs.	—	3	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ARNOLD SAMPSON FISHER

14. MOTHER'S MAIDEN NAME: DOLORES McKEIGHEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mr. Arnold S. Fisher, RFD #1, Elkton, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
754.4 IMMEDIATE CAUSE	(A) Embolism of the meningeal Arteries.	6-8 hours.
ANTECEDENT CAUSE(S) DUE TO	(B) Abnormal pulmonary circulation	3 days.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C) Congenital Heart Disease	3 days.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8.18, 19 56, to 8.21, 19 56, that I last saw the deceased alive on 8.21, 19 56, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

SIGNATURE Peter Shuster M.D. **ADDRESS** (Street, city, town, state) 154 W. Main Elkton, Md. **DATE SIGNED** 8.23.56.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-25-1956	Gilpin Manor Memorial Park	R.D. Elkton Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
8/27/56	H R Frazer	W. Henry Pippin	Elkton, Md.

2065244 XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08192

8220

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2 Mo. 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towson, Maryland
d. STREET ADDRESS: 24 Thornhill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELSON — Middle V. — Last FORD

4. DATE OF DEATH: Month 8 — Day 11 — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-91

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Contracting

11. BIRTHPLACE (State or foreign country): Crisfield, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Ford (Deceased)

14. MOTHER'S MAIDEN NAME: Rachel Nelson (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes ✓ (If yes, give war or dates of service): WW-1

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, abdominal — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Carcinoma of stomach — 6 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized -Abscess , mediastinum, posterior

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from 6-7-56, 19 56, to 8-11-, 19 56 that I saw the deceased alive on [illegible], 19[illegible], and that death occurred at 3:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler, M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): W. Oppler, MD, Chief, Professional Services, VAH., Perry Point, Md. — 8-12-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 8-12-56
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre DeGrace, Md.
PENNINGTON & SON,

24a. REC'D BY REGISTRAR DATE: 8-15-56
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8221

08193

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown Manor
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl Middle: Rachael Last: Frame

4. DATE OF DEATH: Month: 8 Day: 18 Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-10-32

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: house work

11. BIRTHPLACE (State or foreign country): Winchester, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eugene Goodman Sheets

14. MOTHER'S MAIDEN NAME: Mary Katherine McNeal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Eugene G. Sheets. Lester Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowned
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

929.8

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Went in swimming alone and apparently no one knows whathappened

20c. TIME OF INJURY Hour: 9.45 a. m. / p. m. Month, Day, Year: 8-18 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Pond

20f. (City or town) (County) (State): North East Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-19-56

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Aug.20,1956
22c. NAME OF CEMETERY OR CREMATORY: Lamerft
22d. LOCATION (City, town, or county) (State): Chester Penna

23a. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant
ADDRESS: North East Md
Joseph R.Grant North East, Maryland

24a. REC'D BY REGISTRAR DATE: 8-21-56
24b. REGISTRAR'S SIGNATURE: Sarah E. Rothermel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08194

8209

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

LENGTH OF STAY (In this place): 3 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Delaware COUNTY: Kent

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smyrna Landing 4 x 3

STREET ADDRESS (If rural give location): Near Smyrna

3. NAME OF DECEASED (Type or Print): Alice (First) Broadway (Middle) Gaulke (Last)

4. DATE OF DEATH (Month) (Day) (Year): Aug 28 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	widowed	May 27, 1882	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	At Home	Delaware	U.S.A.

13. FATHER'S NAME: William C. Connor

14. MOTHER'S MAIDEN NAME: Cynthia Voss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT & ADDRESS: Mrs. Pearl S. Bailey Earleville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x IMMEDIATE CAUSE (A): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSE(S) DUE TO (B): Paralysis of pharyngeal and laryngeal muscles — 6 day

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C): cerebro-vascular accident — 6 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Inability to swallow, broken ankle two mos previous

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 25, 1956, to Aug 28, 1956, that I last saw the deceased alive on Aug 28, 1956, and that death occurred at 7:45 PM, from the causes and on the date stated above.

SIGNATURE: Wallace Oberlin M.D. — ADDRESS (Street, city, town, state): Cecilton Md. — DATE SIGNED: 29 Aug 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/31/56	Glenwood Cemetery	Smyrna, Del.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
AUG 31 1956	E. R. Frazer	J. C. Wells & Fariss	Smyrna, Del.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08195

8210

CERTIFICATE OF DEATH

Reg. Dist. No. 9 Y

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton

LENGTH OF STAY (in this place) 26 hrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Kent

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey

STREET ADDRESS (If rural give location) 14 x 2

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) GRIFFIN HARRIS

4. DATE OF DEATH (Month) 8 (Day) 23 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	Colored	Single	April 6 1905	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H Griffin	Bertie Warwick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	none	Wilmer Harris Massey Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

199.1 IMMEDIATE CAUSE (A) Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 3 Months

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 8/22, 1956, to 8/23, 1956, that I last saw the deceased alive on 8/23, 1956, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

SIGNATURE John A. Fraser, M.D. ADDRESS (Street, city, town, state) 138 E. Main St, Elkton, Md DATE SIGNED 8/23/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 27 1956	New Bethel Cem.	Galts Md

24. FILED BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
AUG 29 1956	J. R. Frazer	Edward Tilghman Millington Md

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8222

08196

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun

LENGTH OF STAY (In this place) 10 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) WALTER (Middle) A (Last) HALL

4. DATE OF DEATH (Month) 8 (Day) 30 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
M	White	Wid.	9-26-1867	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer.	Cooper.	Lincoln Va	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Timothy Hall.	no information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		—	Effie Wayne Rising Sun Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4232 IMMEDIATE CAUSE (A) Myocarditis

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-1-50 19..., to 6/29, 1954, that I last saw the deceased alive on 8/29, 1956, and that death occurred at 7 P.M, from the causes and on the date stated above.

SIGNATURE R L Dodson M.D. **ADDRESS** (Street, city, town, state) Rising Sun Md **DATE SIGNED** 8/31-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 2 1956	Conowingo Cem	Cecil Co. Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Aug 31 -56	L M Worthington	H L Bailey	Darlington Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8223

CERTIFICATE OF DEATH

08197
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 32yrs1mo.2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: TENNESSEE — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TREZEVANT
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EDWARD — Middle U. — Last HAMES

4. DATE OF DEATH: Month August — Day 19 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 27, 1889

9. AGE (In years last birthday) 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Un known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary tuberculosis, far advanced & active — INTERVAL BETWEEN ONSET AND DEATH: unknown
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Broncho pleural fistula — unknown
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I VA attended the deceased from July 17, 1924, to August 19, 1956, that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 8:10 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 8-19-56

22c. NAME OF CEMETERY OR CREMATORY: Unknown

22d. LOCATION (City, town, or county) (State): Tennessee

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: 8-20-56

24b. REGISTRAR'S SIGNATURE: Irene E. Naughty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8224

68198

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY: CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: PENNA b. COUNTY: ALLEGHENY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 32yrs4mos.15days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PITTSBURGH

75 X — 3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

d. STREET ADDRESS: 740 Hawthorne Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: RAY Middle: Last: HARSHAW

4. DATE OF DEATH Month: August Day: 18 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18,1888

9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Labor Gangs

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Gray Harshaw

14. MOTHER'S MAIDEN NAME: Margaret Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records,VAH., Address: Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Tuberculosis, pulmonary, far advanced, active right	Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Fistula bronchopleural, due to tuberculosis right	Unknown
DUE TO (c)		

002 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from April 3, 1924, to August 18, 1956 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 8-20-56

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Ft. Myer, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — PENNINGTON & SON,

ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: 8-22-56

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08199

8225

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

~~CITY~~ OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombard

LENGTH OF STAY (in this place) 18 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Nottingham RD #1.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombard

STREET ADDRESS (If rural give location) Nottingham RD #1 Pa

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) H. (Last) Hilaman

4. DATE OF DEATH (Month) Aug. (Day) 9 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	April 29 1882	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker	cemetery	Chester Co. Pa.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William A. Hilaman	Catharine Barrett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		218-32-1247	Mary Jane Hilaman Nottingham RD #1 Pa

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 IMMEDIATE CAUSE (A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Colitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1956 to Aug 9, 1956, that I last saw the deceased alive on....., 19....., and that death occurred at 7:30 P.M. from the causes and on the date stated above.

SIGNATURE F.B. Robinson M.D. **ADDRESS** (Street, city, town, state) Oxford Pa. **DATE SIGNED** Aug 9 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/12/56	Rosebank cem.	Calvert Cecil's Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Aug 11-56	Emory Whittington	J. Earl Tyson, Rising Sun, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8226 — 08200 — Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 70 Pierce Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: EARL — Middle: L. — Last: JOHNSON

4. DATE OF DEATH: Month: August — Day: 12 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-18-24

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): D. C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Johnson

14. MOTHER'S MAIDEN NAME: Ruth Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes ✓ (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 579-20-2079

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: unknown
490X
DUE TO
Conditions, if any, which gove rise to immediote cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that VA attended the deceased from August 6, 1956, to August 12, 1956, ~~that I last saw the deceased alive on~~ and that death occurred at 11:15p M, from the couses and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-14-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 8-14-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 8-16-56
24b. REGISTRAR'S SIGNATURE: Irene E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08201

8227

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville

c. LENGTH OF STAY IN 1b: 26 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chesapeake City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: W. Lost: Johnson

4. DATE OF DEATH: Month: August Day: 11, Year: 19 56

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-23-08

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bowling Green, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Johnson

14. MOTHER'S MAIDEN NAME: Mary D. Mecconie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 157-03-7903

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, lower lobes. — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Syringo Bulbia and Syringomyelia — Unknown

DUE TO

(c)

357X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 16, 19 56, to August 11, 19 56 ~~that I last saw the deceased alive on~~ 19, and that death occurred at 2:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 8-13-56

PHYSICIAN'S NAME (Type): W. Oppler, MD, Chief, Professional Services.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-12-56

22c. NAME OF CEMETERY OR CREMATORY: Whites Post Office

22d. LOCATION (City, town, or county) (State): Bowling Green, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 8/14/56

24b. REGISTRAR'S SIGNATURE: Irene E. Haughey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG202 8-27-56 et

08202

8228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: 83
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: near - Woodlawn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Theodore — Middle: P — Last: Kelley

4. DATE OF DEATH: Month: August — Day: 18 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 4, 1873

9. AGE (In years last birthday): 82 Yrs. 8 M. 15 D.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Cecil Co, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Kelley

14. MOTHER'S MAIDEN NAME: Lara E. Fukens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Mallon Kelley, Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
4222
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to 8-15, 1956, that I last saw the deceased alive on 8-17, 1956, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Richards M.D.

ADDRESS (Street, city or town, state): Port Deposit, Md.

DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8/21/56

22c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph M Reed — ADDRESS: Rising Sun, Md

24a. REC'D BY REGISTRAR DATE: Aug 21-56

24b. REGISTRAR'S SIGNATURE: L M Worthington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08203
Reg. Dist. No.

8229

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sylmar. Rural
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sylmar. Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Walter Middle Wilson Last Marshall
4. DATE OF DEATH: Month 8 Day 18 Year 19 56
5. SEX: M. m
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-28-1889
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Sylmar. R.D.Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frances James Marshall
14. MOTHER'S MAIDEN NAME: Chrissiex Magaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 211-22-2721
17. INFORMANT Address: Dean Marshall. Nottingham. R.D. 1. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Hepatitis — INTERVAL BETWEEN ONSET AND DEATH:
580 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: A. Lee Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-19-56
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-21-56
22c. NAME OF CEMETERY OR CREMATORY: Friends Cem. Calvert
22d. LOCATION (City, town, or county) (State): Nottingham, R.D.1 Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. Miller ADDRESS: Rising Sun Md.
24a. REC'D BY REGISTRAR DATE: Aug 20-56
24b. REGISTRAR'S SIGNATURE: L M Worthington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08204

8211 # CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY Cecil — MARYLAND		STATE Maryland COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton	LENGTH OF STAY (in this place) 64 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital		STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ruth	Anna	McCracken	August 2 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Single	February 6, 1869	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher	Retired 27 years	North East Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas C. McCracken	Martha Browne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	None	Mrs Howard Abrahams North East, Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
180X IMMEDIATE CAUSE (A)	Carcinoma of Left Kidney	1 yr.
ANTECEDENT CAUSE(S) DUE TO (B)	—	—
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	—	—
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
		—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.		—

22. I hereby certify that I attended the deceased from May, 1956, to 2 Aug, 1956, that I last saw the deceased alive on Aug 2, 1956, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

SIGNATURE Klaus H. Hansen M.D. **ADDRESS** (Street, city, town, state) North East Md **DATE SIGNED** 2 Aug '56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 5, 56	Methodist	North East, Cecil Co., Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
8/4/56	F R Frazer	Joseph R Grant Joseph R. Grant North East Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8230

CERTIFICATE OF DEATH

Reg. Dist. No. 08205

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: 36 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nellie; Middle: Fay; Last: McGrady

4. DATE OF DEATH: Month: Aug. Day: 14, Year: 1956

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 24, 1904

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Retired School Teacher

11. BIRTHPLACE (State or foreign country): Russell Co. Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James Henry McFadden

14. MOTHER'S MAIDEN NAME: Rachel Jackson Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Glenn McGrady Address: Port Deposit Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastasis to Brain — 3 Months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7, 1956, to Aug 14, 1956, that I last saw the deceased alive on Aug 13, 1956, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Port Deposit Md.

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/18/56

22c. NAME OF CEMETERY OR CREMATORY: Smiths Chapel

22d. LOCATION (City, town, or county) (State): Churchvill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas E. Mullen — ADDRESS: Rising Sun Md.

24a. REC'D BY REGISTRAR DATE: Aug 17

24b. REGISTRAR'S SIGNATURE: L.M. Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8231

CERTIFICATE OF DEATH

Reg. Dist. No. 08206

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 4yrs.1mo.2das
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8202 - 12th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle J. — Last Mc LEAN

4. DATE OF DEATH: Month August — Day 19 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-72

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): SAW

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, lower lobe, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 6-8-days
420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary heart disease, severe — unknown

DUE TO

(c) Arteriosclerosis, general, severe — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I VA attended the deceased from July 18, 1952, to August 19, 1956 that I last saw the deceased alive on [illegible] and that death occurred at 8:40p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-20-56

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Nalley's Funeral Home, Mount Rainier, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 1956

24b. REGISTRAR'S SIGNATURE: Irene Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8232

CERTIFICATE OF DEATH

Reg. Dist. No. 08207 56

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: 43 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 109 N. Main St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 109 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Louise — Last: Nesbitt

4. DATE OF DEATH: Month: Aug. — Day: 19 — Year: 19 56

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-19-1878
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Gray
14. MOTHER'S MAIDEN NAME: Mary Mace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Russell Locke, Port Deposit, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardiosis & Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
(b): Arteriosclerosis — 5 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 56 to Aug 19, 19 56 that I last saw the deceased alive on Aug 19, 19 56, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. H. Richards Jr. M.D.
ADDRESS (Street, city or town, state): Port Deposit, Md
DATE SIGNED: 8-21-56
PHYSICIAN'S NAME (Type): G. H. Richards, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/22/56
22c. NAME OF CEMETERY OR CREMATORY: Harmony Chapel
22d. LOCATION (City, town, or county) (State): Liberty Grove, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Patterson & Son
ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: 8-21-56
24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8233

68208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18FilmG202-9-1 Item 9 FilmG202 9-4-56 et

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun
c. LENGTH OF STAY IN 1b 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Route 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun
d. STREET ADDRESS Rural 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ANNA Middle: BELIA Last: OLDIS
4. DATE OF DEATH Month: 8 Day: 26 Year: 1956
5. SEX F.
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9 17 1878
9. AGE (In years last birthday) 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY House Work
11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME N. Robert Poole
14. MOTHER'S MAIDEN NAME Catherine A Perry.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address: Garrett Oldis Rising Sun Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation — INTERVAL BETWEEN ONSET AND DEATH
795.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) due to inability to retain food.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R L Dodson M.D.
EXAMINER'S NAME (Type) R C Dodson
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8/27/56

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF AUG 28. 1956
22c. NAME OF CEMETERY OR CREMATORY METHODIST
22d. LOCATION (City, town, or county) (State) BAY VIEW CECILCA. Md

23. FUNERAL DIRECTOR'S SIGNATURE Joseph S Gray ADDRESS North East Md
24a. REC'D BY REGISTRAR DATE 8-28-56
24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8234 08209

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 27yrs.11mo.26days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mississippi
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Columbus
d. STREET ADDRESS: 1016 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle R. C. — Last PEYTON

4. DATE OF DEATH: Month August — Day 9 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-20-1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E. G. Peyton

14. MOTHER'S MAIDEN NAME: Annie Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abscess retroperitoneal, right lower abdomen (following operation) — INTERVAL BETWEEN ONSET AND DEATH: 10-15 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Necrosis of the right ureter — 3-5 weeks
(c) DUE TO: Pyelonephritis, right — 10-15 days
Carcinoma of the anus — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal ulcer, multiple (unknown)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 14, 1928, to August 9, 1956, that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at 9:20 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W Oppler M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 8-10-56

PHYSICIAN'S NAME (Type): W. OPPLER
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 8-10-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 8-13-56
24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8235

08210 96

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio — b. COUNTY: Columbiana

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point

c. LENGTH OF STAY IN 1b: 3 Yrs. 9 Months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): E. Liverpool

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

d. STREET ADDRESS: 409 Wall Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: E. — Last: Putnam

4. DATE OF DEATH: Month: 8 — Day: 19 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-19-82

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Wellsville, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Archie Putnam

14. MOTHER'S MAIDEN NAME: Ufemia Mac Cord

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Peacetime

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH, PerryPoint, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar Pneumonia, Bilateral, Lower Lobes, Unresolved — INTERVAL BETWEEN ONSET AND DEATH: 7-10 Days

490?

DUE TO (b): Emphysema, Bilateral, Severe — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized, severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-21-52, 19__, to 8-19, 1956, that I last saw the deceased alive on ~~[illegible]~~ 19__, and that death occurred at 12:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-19-56

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: 8-21-56

24b. REGISTRAR'S SIGNATURE: Irene E. Donaghy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 68211

8212

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

LENGTH OF STAY (in this place): 5 weeks

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Morton (Middle) E. Reeder (Last)

4. DATE OF DEATH (Month) August (Day) 6 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Msrried	August 4,1888	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Ret 3 yrs U.S.Public Health

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel J.Reeder

14. MOTHER'S MAIDEN NAME: Mary Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give wer or dates of service)

16. SOCIAL SECURITY NO.: 313-34-8610

17. INFORMANT & ADDRESS: Mrs Blanche R.Reeder,North East,Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X IMMEDIATE CAUSE (A): Cardiac Cirrhosis of Liver — Interval between onset and death: 1yr.

ANTECEDENT CAUSE(S) DUE TO (B): Hypertensive Cardiovascular Renal Disease — 10yrs +

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

240X

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Diabetes Mellitus, Bronchial Asthma — 10yrs. +

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): —

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.): —

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State): — — —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.: —

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May, 1946, to 6 Aug, 1956, that I last saw the deceased alive on 5 Aug, 1956, and that death occurred at 6:40 A.M. from the causes and on the date stated above.

SIGNATURE AND M.D.: Klaus H. Hamburger M.D.

ADDRESS (Street, city, town, state): No. 44 E. St. Rd

DATE SIGNED: 6 Aug '56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 9, 56	Methodist	North East, Cecil Co., Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
8/8/56	H R Frazer	Joseph R Ling	North East, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08213

8236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Andy	Marshall	Soots	8	3	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		9-29-1909	46 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	All kinds ow work	North Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Soots	Minnie Oerdue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes No. 2	246-09-7024	John Soots North East. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ~~Drowned~~ — INTERVAL BETWEEN ONSET AND DEATH

975 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

Jumped into North East Creek and swam across and laid in water.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
7 o. m. p. m.	8 3 1956		North East Creek.	North East Cecil Md.

21. I certify that I taak charge of the remains described above, held an Autopsy ☐, Inspectian ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): R.C.Dodson — 8-4-56

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	August 4,56		Midland Cabarrus Co N.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph R Grant NorthEast Maryland	aug 6-56	Sarah E. Rothermel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08212

8237

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 14 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veteran Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORTH EAST
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLOYD — Middle R. — Last SMITH

4. DATE OF DEATH: August 19, 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: February 11, 1895

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES SMITH

14. MOTHER'S MAIDEN NAME: SUZIE RYAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia right lower lobes, unresolved	48 hrs.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Infarction of the interventricular septum	72 hrs.
DUE TO (c)	Coronary sclerosis severe	unknown

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, general (unknown)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from August 5, 1956 to August 19, 1956 that I last saw the deceased alive on ____, 19____, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler — M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-20-56

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — JOSEPH R. GRANT FUNERAL HOME, — ADDRESS: North East, Md.

24a. REC'D BY REGISTRAR DATE 8-20-56

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8238

CERTIFICATE OF DEATH

08214
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nurseing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
d. STREET ADDRESS: Route 222
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elam — Middle: Roth — Last: Werntz

4. DATE OF DEATH: Month: Aug — Day: 25 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): nO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-2585

17. INFORMANT: Address: Mrs Erma McSpadden Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH:
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-15, 1956 to 8-25, 1956, that I last saw the deceased alive on 8-25, 1956, and that death occurred at 5:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun Md — DATE SIGNED: 8-25-56

PHYSICIAN'S NAME (Type): R C Dodson MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-28-1956

22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee a Patterson & Son — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: Aug 27-56

24b. REGISTRAR'S SIGNATURE: Em Worthington

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8239

CERTIFICATE OF DEATH

08215 96
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Hartford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 502 S. Philadelphia Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12-31-2

3. NAME OF DECEASED (Type or print): First Joseph — Middle A. — Last Wheeler

4. DATE OF DEATH: Month August — Day 19 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-22-92

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dispatcher

10b. KIND OF BUSINESS OR INDUSTRY: Automotive (Gov't)

11. BIRTHPLACE (State or foreign country): Bel Air, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Barnett Wheeler (Deceased)

14. MOTHER'S MAIDEN NAME: Agnes Bradley (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 3-4 Days

DUE TO
(b): Glioblastoma, multiforme of brain, recurrent involving right occipital and parietal lobes — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

193X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from 8-8- 19 56, to 8-19- 19 56, that I last saw the deceased alive on [illegible], and that death occurred at 2:35A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: William M. Harris M.D. M.D.

PHYSICIAN'S NAME (Type): WILLIAM M. HARRIS, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8-19-56

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John E. Garring Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: 8-19-56

24b. REGISTRAR'S SIGNATURE: Irene E. Dougherty

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8240

08216

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton Rural
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Siri Middle Last Willis
4. DATE OF DEATH: Month 8 Day 9 Year 1956
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-23-1906
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Minnisota
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Oscar Johnson
14. MOTHER'S MAIDEN NAME: Katie F. Paarola
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ———
17. INFORMANT Address: Walter Willis. Elkton. R.D.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b) Malignant Hypertention
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-10-56
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-12-1956
22c. NAME OF CEMETERY OR CREMATORY: North East Cemetery
22d. LOCATION (City, town, or county) (State): North East Md.
23. FUNERAL DIRECTOR'S SIGNATURE: B Henry Tippin ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 8/14/56
24b. REGISTRAR'S SIGNATURE: H R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

08217

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G201 8-13-56 et

8241

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

LENGTH OF STAY (in this place): 56 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) William (Middle) P (Last) Wyre

4. DATE OF DEATH (Month) (Day) (Year): August 3 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	Feb 25,1880	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fish Net Maker		Delaware	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eli Wyre	Frances Frezze

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	none	Howard Wyre North East, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2yrs.

ANTECEDENT CAUSE(S) DUE TO (B) —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	—	— — —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.		—

22. I hereby certify that I attended the deceased from Feb, 1956, to 3 Aug, 1956, that I last saw the deceased alive on 27 July, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above.

SIGNATURE Klaus H. Henkens M.D. **ADDRESS** (Street, city, town, state) North East Md **DATE SIGNED** 3 Aug '56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 6,1956	Methodist	North East, Cecil Co, Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE aug 6-1956	Sarah C Rothermel	Joseph R Grant	North East, Maryland